GRACE
Gynecology & Wellness

Authorization to Release Health Care Information

Patient's Name: _____

Previous Name: _____ Date of Birth: _____

Best Contact #: _____

I request and authorize **Grace Gynecology & Wellness** to release confidential health information by releasing a copy of the medical records of the above named patient to:

Physician/Clinic: _____
Street Address: _____
City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____

This request and authorization applies to:

_____ All healthcare information.
_____ Healthcare information relating to the following treatment, condition, or dates of treatment: _____
_____ Other: _____

The reasons/purpose for this release of information are: _____

_____

_____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information related to such diagnosis, testing, or treatment.

_____ _____
Signature of Patient or Patient's Authorized Representative Date Signed

Relationship or status if signed by anyone other than patient: _____
(Example: parent, legal guardian, personal representative, etc.)

This authorization expires 180 days after the date it is signed.

A $25.00 processing fee may appLy.